

## **Doing a Lot with a Little: How to Start a Police Department-Based Opiate Outreach Program**

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Today in the United States, drug overdoses are the leading cause of accidental death for people aged 25 to 64. Opiate overdoses are driving this epidemic, quadrupling in number since 2011. As the epidemic moves from disenfranchised neighborhoods to the suburbs, policy makers and politicians are taking notice. Seeking solutions and strategies, they are turning to programs embedded in police departments. These programs originated from necessity, as first responders witnessed the ravages of this epidemic firsthand. Before there was interest in policies, and predating the media attention, municipal police departments were responding to the growing crisis. In this article, I document how one police department-based program in Arlington, Massachusetts, did just this, how we achieved positive outcomes with slim resources, and what we learned along the way. I then offer steps for replicating this successful model.

We need to treat the current plague of opiate deaths as we would any epidemic. That means we must move thoughtfully and quickly. My hope is that by showing how we proactively created our own model, and offering guidelines for replicating it, other police departments can create and implement programs to meet their community's needs. Our Arlington Model is comprehensive: Its components of triage, education, prevention and acute intervention are all necessary in combating a full-fledged epidemic. This model protects people once they overdose, offers community and family interventions, and provides access to a wide range of treatments, education and support within our community. This is all achieved without a significant allocation of resources or a decrease in the general productivity of the police officers involved.

### **The story of the Arlington Model**

I am a mental health clinician embedded in the police department in the town of Arlington, a suburb outside Boston. Typically, my job involves assisting the police when they intervene with individuals experiencing psychiatric symptoms. As any officer will tell you, this is a daily occurrence in police departments, and the addition of a mental health clinician not only helps officers work more efficiently, but also increases the department's ability to serve and protect a vulnerable population. In this capacity, I am often involved with other behavioral health concerns, including substance abuse.

In Massachusetts, the number of confirmed unintentional overdose deaths for 2014 was 1,089 – a 63 percent increase from 668 deaths in 2012. The Arlington Police Department began tracking overdoses in the community in 2013. That year, there were eight overdoses and two were fatal. In 2015, there were thirty-four overdoses, six of which were fatal. The death of a young and beloved local woman drove us to take action. Three times in one week she overdosed from heroin, and twice, first responders saved her life using nasal Naloxone (naloxone, a temporary opiate blocker). She did not survive her third overdose that week. As we reviewed the first responder interventions prior to her death, and compared them to other opiate-related deaths in Arlington, her story became instructive in two ways: (1) some of these deaths might have been preventable; and (2) prevention approaches need to precede the moment of crisis. We saw in our data that people who overdosed on opiates often overdosed again. We needed to find a way to

reach individuals at risk, their families and friends, with lifesaving technology and training before the next overdose.

### **Here is what we did:**

Step One: Educating the Public and Widening Access to Naloxone. It was time to get people talking about opiates. In the spring of 2014, the Arlington Health and Human Services and Police departments held our first opiate overdose prevention community event, called Naloxone Night. We invited the community through social media, our town website, local newspapers, local cable television and flyers around town. Thirty-five people attended, many of whom were family members of people using opiates. The police chief, Fred Ryan, hosted Naloxone Night, thus establishing our police department as a partner eager to help. The event featured three speakers:

- 1) A court clinician explained how to commit someone for substance abuse treatment through the courts. (In Massachusetts, that's a Section 35.)
- 2) A certified interventionist talked about his own addiction. He also offered to connect people to treatment, and he committed to providing free private interventions. (This gentleman, Mike Duggan, founder of Wicked Sober, became a key member of our team, continuing to volunteer his time to facilitate entry to treatment.)
- 3) Staff from the local needle exchange program discussed the physical signs of overdose, demonstrated administration of Naloxone, instructed individuals in how to administer it, and provided free double-dose Naloxone kits to those who wanted them.

We achieved three goals with Naloxone Night that would later mark our comprehensive approach: 1) Education for families and those struggling with addiction; 2) distribution of Naloxone; and 3) access to services for those seeking help.

We learned from Naloxone Night that people in our town were hungry for information regarding the opiate epidemic. Wanting to reach a larger audience beyond individuals interested in Naloxone, our local drug abuse prevention coalition held a public forum at our town hall called *The Opioid Crisis: Identifying Community Solutions*. The forum was moderated by Chief Ryan, its purpose being to widen our audience from individuals directly affected by drug abuse, to the larger community. Our panel consisted of state Attorney General Maura Healy; District Attorney Marian Ryan; Dr. Alex Walley, Director of the Massachusetts Department of Public Health's Opioid Overdose Prevention Program; Mike Duggan, interventionist and founder of Wicked Sober, and myself. Over one hundred people attended the forum. It was recorded and broadcast on local cable and is available online.

Because of the increasing number of overdoses in Arlington and spurred by the successes of Naloxone Night and the town forum, I asked Mike Duggan to co-facilitate twice-monthly community meetings. We called this component of our program, Arlington ACTS (Addiction, Community, Training and Support). Arlington ACTS meetings offer a place for community members to get information and connect to resources. The meetings begin with an outside speaker, followed by offers of access to treatment, and ending with distribution of, and training in, Naloxone use.

Step Two: Removing Surplus Prescribed Opiates from the Community. In an effort to remove potentially addictive drugs from the town, Arlington was already hosting drug take-back days. On designated days, at a table set up in front of the police station, residents drop off unneeded drugs. The police department also installed a permanent kiosk in the police station lobby for 24/7 drop-off. Arlington then went a step further by organizing proactive drug take-back at its elderly public housing buildings, thereby eliminating the obstacle of transportation and removing unneeded prescription drugs from the community. Over the past three years, these efforts have resulted in the destruction of more than 61,000 prescription drugs.

Step Three: Targeting Those Most at Risk. The individuals who actively use heroin are the least likely to attend our Arlington ACTS meetings. The more chronic the use, the more likely the person is afraid of contact with the police. While Naloxone is available in pharmacies without a prescription, these individuals are often reluctant to go to pharmacies to get it, due to stigma, misinformation or the foresight required to make such an effort. If we really wanted to decrease opiate deaths, we needed to reach the people abusing opiates, and we needed to show them they could freely ask for help.

Naloxone is clearly not a cure-all for the crisis of opiate deaths. Like CPR, it is an effective lifesaving technique, but does little to prevent life-threatening behaviors or illnesses. However, as we distributed this medication at the ACTS meetings, I began to realize that the way it is dispensed has its own preventative properties. I saw that Naloxone could be a way to reintroduce police officers to people who use substances; that it might shift the dynamic between the two in a positive way. If police department personnel distributed Naloxone to individuals most in need, the medication became a kind of handshake, a symbol that the police were there to help users, not simply to arrest them.

During the period that our program was expanding, no police departments in Massachusetts distributed Naloxone. Chief Ryan met with the Town's legal department to develop a plan. At the attorneys' suggestion, a group from the Arlington Police Department and the Arlington Health Department were trained by a Massachusetts Department of Public Health master trainer, to teach others to identify and respond to an overdose and to administer Naloxone. A town attorney drafted a waiver of liability for Naloxone recipients to sign. With Chief Ryan's support and encouragement, the Arlington Police Department became the first police department in Massachusetts to train and distribute Naloxone to the community.

As the police department Clinical Responder, I have access to police reports, so I began reaching out to everyone who had recently overdosed. In addition, police officers – always very aware of what is going on in the neighborhoods they patrol -- started to share with me their concerns about residents, and I would reach out to offer help. After an overdose, or after I receive information from an officer about someone of concern, I call the person and anyone else listed on the report, to offer Naloxone and treatment options. If I can't reach people by phone, I go to their home. If they refuse to see me, I make sure they understand they can contact me when and if they decide they want help.

Through proactive community policing and outreach to individuals with a history of overdose, we were able to locate and reach out to our community's most at-risk individuals. This approach of targeted Naloxone distribution is working, not only in getting Naloxone into the right hands, but in helping people enter treatment. It also works in making that first "handshake" mentioned

above. In some instances, people reach out to me for help days or even weeks after declining my offer of help on the initial call.

Step Four: Access to Treatment: Inspired by the Gloucester Program, a police department-based model in which police officers help individuals access treatment, we wanted to create our own means for achieving this goal. Finding detox beds or treatment facilities can be challenging and time-consuming because of high demand and limited numbers of beds. If you are addicted to substances and are ready to commit to treatment, calling multiple facilities and being rejected can be discouraging and overwhelming. We were lucky to find a solution in our volunteer interventionist, Mike Duggan. Mike assists residents in locating treatment beds, also working with families of people reluctant to engage in treatment.

Through our assertive distribution of Naloxone, community education, and methods for helping people find the appropriate level of care, the Arlington Model was beginning to take shape as a small-scale epidemic response. Reviewing what we had accomplished, we identified one more element that would complete our comprehensive model: We wanted to find a way to stem the hemorrhage of use. We were far from naïve — we knew the road to recovery is a marathon, not a sprint — but our goals were modest.

Step five: Relapse Prevention: At an Arlington ACTS meeting, a gentleman in recovery stated that one of the most difficult times for someone struggling with addiction is often the first day home from treatment. Once home from the restrictive environment of a treatment center, a person is often left to their own devices with little to do and no support structure. We wanted to find a way to welcome them back and ensure they would have support. Our solution was to inform the community about our Coming Home Day program. We encourage anyone being discharged from treatment to call us. We arrange for a community volunteer to meet with them on the day of discharge and bring them to an AA meeting or help link them to other services. Coming Home Day is a kind of social or community relapse prevention, bridging the precarious gap between inpatient care and community living. There are also powerful pharmacological means to prevent relapses, and we wanted access to these as well.

There is a growing body of evidence that certain pharmacological interventions can help in a person's recovery by blocking the effects of opiates so the individual can engage in treatment and have a chance at recovery. While Naloxone is a short-term opiate antagonist, quick-acting on an overdose, Vivitrol (Naltrexone) blocks the euphoric effects of opiates longer-term (up to 28 days). We wanted to give people abusing opiates easy access to this medication. Partnering with a local clinic that offers Vivitrol, we invited their nurse to an ACTS meeting. We used every means possible to advertise this important meeting to the town, including a recorded message from Chief Ryan using the "all-town" reverse 911 alert system, in which every person who has signed up is contacted. Attendance was overwhelming, and we allowed plenty of time for discussion. We announced at the meeting that the police department would be providing taxi cab vouchers to the clinic for individuals seeking Vivitrol treatment.

Since that meeting, during my follow-up calls and visits to individuals who have overdosed, my intervention plan consists of offering four resources: 1) Naloxone and Naloxone training; 2) access to our volunteer interventionist, who can help with a referral to treatment; 3) information on Vivitrol and an offer of a taxi voucher to any anti-opiate medication appointment; and 4) information for family members on how to implement a Section 35 commitment.

## **Replicating the Arlington Model**

Police departments vary in how they operate, as do municipalities. In the midst of a crisis, when time is of the essence, departments should not struggle to duplicate what we did in Arlington. Instead, they should work as quickly as possible to replicate, in their own way and to the degree possible, the goals and outcomes of a multifaceted model that has proven successful. Our model offers a comprehensive first-responder-driven response to an immediate epidemic crisis. We believe that responding to an epidemic emergency quickly and effectively, requires six elements. Here are guidelines for implementing the six elements of our initiative:

1. Create Partnerships: Work with your health and human services department, school department, local detox facilities, local emergency rooms, local needle exchange/harm reduction organizations and local treatment providers. These facilities may be willing to help by providing or finding services for individuals. Attempt to engage state governmental officials outside your town for help in linking to other departments and spreading the word about the epidemic in your town.

The Arlington Model has been a team effort. Our police, fire, health and school departments, health care providers as well as private citizens and local faith organizations, have all contributed.

2. Harm Reduction: Partner with your health department and find your local needle exchange/harm reduction programs. They will likely be willing to teach your community about overdoses and how to distribute Naloxone. The state department of public health can probably give you a list of these organizations. In Massachusetts, there is a standing order to pharmacies allowing people to get Naloxone without a prescription, and Naloxone is covered by most insurances. If your state has such an order, research which local pharmacies carry Naloxone, and get this information out to your community. If you are not able to distribute Naloxone on an outreach basis, you may still be able to distribute it at public forums. If you are unable to distribute it at all, try to find other ways of notifying the public about Naloxone, and/or use the communications systems in your town to educate the public on overdose prevention.

3) Educate the Public: Hold public education forums. Invite speakers from local organizations to inform your residents. Use the communication systems available – from local cable and newspapers to your town's web site and social media -- to educate your community about opiate misuse and treatment. Partner with another town and hold an event. Look for other towns that hold open meetings. As mentioned, our town has a drug take-back kiosk and it is filled to capacity and emptied regularly, resulting in the removal of thousands of prescription drugs from the community each year. If possible, go to your public housing buildings and offer drug pick-up.

4) Assertive Outreach. If your police department does not have the means to offer Naloxone, or the opportunity to form partnerships with local treatment providers, or the funds to provide transportation to anti-opiate medication or other treatments, you can simply make phone calls to users or others involved, checking in with them and offering referrals to resources that do offer assistance and education on overdose prevention.

5) Referrals. If your local police department is unable to hire or find an outside person to help people access services, they can try asking someone working for the town, such as the town nurse or staff from the local health department. Making a few phone calls to find treatment for someone is not time-consuming; and the calls could save a life and be less time-consuming than responding to future overdoses. Police departments might also ask for collaboration from Alcoholics Anonymous (AA) and similar groups in town.

6) Treatment. Many towns might find it difficult to readily access anti-opiate treatment, or they might not wish to focus on this kind of treatment as an immediate response. A possible solution is for these police departments to develop a relationship with a local AA, NA, and/or Learn to Cope chapter which can provide support. Individuals in AA are accustomed to helping people attend their first meetings. Reach out to the meeting facilitator and ask them to offer a volunteer-staffed Coming Home Day program.

### **Don't reinvent the wheel**

Chief Ryan, police captains within the department, our interventionist and I have visited over thirty-five police departments in Massachusetts and throughout the U.S., offering education and consultation based on our experience creating the effective Arlington Model. Upon request, I email our written materials to police departments interested in our initiative. I encourage them to use our materials any way they can to make the program their own.

Across the country, police departments are quickly and creatively using limited resources to address the opiate misuse epidemic, from creating positions called "Harm Reduction Clinician" to designing small assignments for civilian staff. Police departments can do a lot with a little to offer an effective first response to the epidemic.

The conversation has changed; stigma must be set aside if we want to save lives. Our model is an example: We provide a program that is comprehensive and effective, yet no staff in our town are dedicated full-time to the epidemic. Instead, we use a team approach designed strategically and tactically to assist those people most in need. As a result, we are able to provide a quick, compassionate and effective response to this crisis.